SAFE FUND

REQUEST FOR PAYMENT FROM DEPARTMENT OF JUSTICE

(ATTACH THIS FORM TO EACH BILL, ALONG WITH AN ITEMIZED BILL)

To: Wisconsin Department of Justice
SAFE Fund
PO Box 7951
Madison, WI 53707-7951

Date: _____

Hospital/Provider Name: _____

Address: _____

_____

Billing Contact Person Name: _____

Contact Person Telephone Number: _____

Name of Patient: _____

Reason for Safe Fund Payment:
___ Did not wish to report to law enforcement
___ Did not wish to cooperate with law enforcement
___ Did not wish to submit bill to insurance provider for reasons of privacy or confidentiality. Reason: _____
_____
_____
(note: MA, Title XIX, does not generally fit into this category)